



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Region 10
M/S RX-40
2201 Sixth Avenue
Seattle, Washington 98121

August 17, 2001

Dear Tribal Leader:

This is one in a series of letters regarding American Indian and Alaska Native (AI/AN) health policy issues and the Medicaid program. This letter transmits a copy of a letter to State Medicaid Directors regarding outstationing of trained workers in Tribal facilities and Urban Indian health care facilities for the purpose of assisting potential Medicaid beneficiaries with the application process for Medicaid.

States are required under Federal law and regulations to establish outstation locations at each disproportionate share hospital (DSH) and each Federally Qualified Health Center (FQHC) participating in the State's Medicaid program unless the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration approves an alternate plan that includes other sites and at least some FQHCs and DSH hospitals. Tribal facilities operating under the Indian Self-Determination and Education Assistance Act (Public Law 93-638) and Urban Indian health care facilities are included in this requirement. If your facility does not participate in the State's Medicaid program either as a fee-for-service or managed care provider, then your facility would not be included in this requirement.

We are aware that distance, language and cultural issues are among the barriers to enrollment in Medicaid among AI/ANs. Outstationing of trained Tribal members or other trained individuals to assist in the application process at a Tribal or urban facility is one method by which these barriers may be overcome. The enclosed letters (SMDL #01-008 and SMDL #01-025) encourage States to work with Tribal FQHCs and Urban Indian health care facilities to ensure the requirements of the law are met in a manner that is mutually acceptable. The letters also inform the States that Section 708 of the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 add new entities to the list of those qualified to make Medicaid presumptive eligibility determinations for children. This list includes certain elementary and secondary schools including those operated or supported by the Bureau of Indian Affairs, State or Tribal child support enforcement agency, or an organization that is providing emergency food and shelter under the Stewart B. McKinney Homeless Assistance Act.

If you have any questions or would like to discuss this issue further, please feel free to call me or the Native American Contact (NAC) in your CMS Regional Office. A list of the NACs and the States they cover is enclosed with this letter. A copy of this letter will be sent to the Medicaid Directors in your State.

We look forward to working with you on this and other initiatives.

Sincerely,

A handwritten signature in black ink that reads "Linda A. Ruiz". The signature is fluid and cursive, with the first letters of each name being capitalized and prominent.

Regional Administrator

Enclosures

cc:

Dennis Smith

State Medicaid Directors

Tribal Health Directors

Indian Health Services Area Directors, Alaska and Oregon

Lee Partridge, Director, Health Policy Unit, American Public Health Services Association

Joy Wilson, Director, Health Committee, National Conference of State Legislatures

Matt Salo, Director of Health Legislation, National Governors' Association

Sally Smith, Chairperson, National Indian Health Board

Michael Trujillo, MD, Director, Indian Health Service

Merle Boyd, Chair, Tribal Self-Governance Advisory Committee, Indian Health Service

James Mason, Acting Director, Intergovernmental Affairs, Indian Health Service

Brent Ewig, Association of State and Territorial Health Officials

Susan Masten, President, National Congress of American Indians

Barbara Namias, President, National Council of Urban Indian Health



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850
SMDL # 01-008

January 18, 2001

Dear State Medicaid Director:

I am writing concerning the requirement that States provide pregnant women and children opportunities to apply for Medicaid at locations other than welfare offices, such as Federally Qualified Health Centers (FQHCs) and disproportionate share hospitals (DSH).

Studies demonstrate that application sites outside the welfare office can greatly assist States in their efforts to enroll eligible children in Medicaid and the State Children's Health Insurance Program. Recent studies by the Kaiser Commission on Medicaid and the Uninsured and by George Washington University find that parents say they are much more likely to enroll children in Medicaid if they could do so in convenient locations within the community, such as a doctor's office or clinic, or a school or day care center.

This finding is supported by States' own experiences; many States have found outstationing to be a particularly effective strategy to enroll eligible children and their families and to address stigma issues that may arise when welfare offices are the primary point of entry into Medicaid. The need for outstationing has grown in importance as an increasing number of persons who are not eligible for either cash assistance or food stamps can establish eligibility for Medicaid and do not otherwise have a need to go to a welfare office. In addition, many people, such as homeless persons, frequently do not consider health coverage until a need for health care services arises. The opportunity to apply at the provider site can greatly facilitate enrollment in these circumstances.

Information that the Health Care Financing Administration (HCFA) has received from the Temporary Assistance for Needy Families (TANF)/Medicaid reviews, the Department of Health and Human Service's (DHHS) Office of the Inspector General, and university-based studies suggests that States are not all in full compliance with the outstationing requirement found at section 1902 (a)(55) of the Social Security Act, as implemented by regulations at 42 CFR 435.904. While the regulations give States considerable flexibility to determine how best to comply with the outstationing requirements, States must comply with the mandatory requirements imposed by this longstanding statutory provision and the implementing regulations. In this letter, we review both the requirements and flexibility to ensure States understand what is required and how the flexibility offered by the regulations can be used to meet these requirements in an effective and efficient manner.

In addition, we encourage you to expand your outstationing efforts beyond what the law and regulations require. Utah, Georgia, and Indiana, for example, have moved staff out of the traditional office setting into the community, and recognized staff activities to promote clearly

articulated enrollment goals. The result, as reported by these States, has been increased enrollment, a higher level of staff satisfaction and lower turnover rates, and increased overall program satisfaction on the part of families and the provider community

Requirements and Options

1. Outstation Locations

A. Requirements

Locations at Each FQHC and DSH Hospital

In general, unless a State has demonstrated to the HCFA that it has an equally or more effective alternative plan for outstationing, it must establish outstation locations at each DSH hospital and each FQHC participating in the State's Medicaid program.

For outstationing purposes, FQHC means an entity that meets the definition in section 1905 (l)(2)(B) of the Social Security Act. It includes an entity receiving a grant under section 330 of the Public Health Service Act; an entity receiving funding under a contract with the recipient of a section 330 grant that meets the requirements to receive a section 330 grant; an entity that the Secretary determines meets the requirements to receive a section 330 grant (FQHC look-alike); and an entity that was treated by the Secretary for purposes of Medicare Part B as a comprehensive Federally-funded center as of January 1, 1990. It also includes an outpatient program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary care services.

FQHCs are particularly important sites for outstationing because most, if not all, FQHC sites are frequently used by pregnant women and children. According to DHHS data, nationally, 59.4 percent of the 10 million FQHC patients are women and children below 200 percent of the Federal poverty line and 77 percent of FQHC patients are either receiving Medicaid or are uninsured. While we encourage States to consider outstationing at sites in addition to FQHCs and DSH hospitals (see options below), we strongly encourage States to comply with their outstationing obligation by outstationing at each FQHC site. As explained below there is significant flexibility in the regulations for staffing and implementing outstationing arrangements. For example, the regulations do not require State staff to be placed at each outstation location. There are various other ways that outstationing can be effectively implemented at most or all sites operated by an FQHC, through rotational arrangements, use of provider staff, and other means. Broad access at multiple FQHC sites greatly enhances the opportunities to enroll Medicaid-eligible children and families.

Alternate Outstationing Plan

Under the regulations, a State may develop an alternate outstationing plan it is reflected in the State's Medicaid plan and approved by HCFA. The regulations permit States to develop an alternate plan that includes at least some FQHCs and DSH hospitals and other locations. The State must demonstrate that the alternate plan is an equally or more effective method for reaching the target group, and that an equivalent level of funding and staffing would be committed to implement the alternate plan.

In reviewing these State Plan Amendments (SPAs), HCFA will take into account the following considerations and factors:

- number of full time equivalents (FTE) State staff and non-State staff devoted to outstationing under the alternate plan;
- number and location of FQHC and DSH hospital outstation location sites that will be part of the alternate plan and the number and location of FQHC and DSH sites that would not serve as outstation sites under the plan;
- the type, location and activity level of alternate sites under the plan;
- hours of operation of outstationing sites;
- number of sites that will provide initial application enrollment services only and the number of sites where eligibility determination will be made on site;
- availability of translation services at outstationing sites;
- available data on use of sites included in the alternate plan by pregnant women, infants, and children under 19 and available data on such use at the FQHC's and DSH hospitals not included in the plan;
- method for informing the public of the new sites; and
- any other pertinent data, information, or studies that have a bearing on the effectiveness of the alternate plan; and
- the method proposed by the State to evaluate the effectiveness of the plan.

B. Options

Outstation at Every FQHC or DSH Hospital Satellite

The regulations do not require States to outstation staff at every satellite site operated by a DSH hospital or FQHC. However, in order to be consistent with the intent and spirit of the law and regulations, all sites that are frequently used by pregnant women and children should be outstation sites.

Outstation at Additional Locations

Outstation sites need not be limited to required outstation locations or locations that provide health care services. Additional sites may include school-linked service centers, family support centers and other community-based organizations that provide support services, homeless health

centers and other community-based health care provider sites, job service centers, day care centers, and Head Start and other programs that provide support services to pregnant women, families, or children.

Beyond the requirements and choices available under the regulations which implement the outstationing requirement of the law, States are free to outstation State eligibility workers at any location that they believe will help facilitate the enrollment of families and children into Medicaid. In addition, outstationing can be used to facilitate the enrollment of other individuals into Medicaid, such as homeless persons and persons that are dually eligible for Medicare and Medicaid.

2. Outstation Functions

A. Requirements

Initial Processing of Applications

At a minimum, applications must be received and initially processed at each outstation location. Initial processing includes taking applications, providing information and referrals, obtaining required documentation, ensuring that information on the application form is complete, and conducting any required interviews. It does not include evaluating the information and making the determination of eligibility.

All initial processing activities must occur at the outstation location. Therefore, for example, if the State requires a face-to-face interview, the State must arrange for the interview to be completed at the outstation location. Requiring the applicant to go to the local welfare office to complete the interview defeats the purpose of the outstationing requirements.

Proper application forms must be available at all locations.

B. Options

Determine Eligibility at Outstation Locations

In addition to initial processing, the determination of eligibility can be made at the outstation location by State staff authorized to make eligibility determinations. To the extent the State has staff available for this purpose, it promotes the proper and efficient administration of the program to do so.

Link Outstation Sites to Automated Information Systems

States also may consider linking outstationed sites to their automated information system so that applications taken at the outstation site can be input directly into the system. Safeguards would be needed to ensure that outstation workers who are not State employees only have access to

information they are permitted to see under Federal and State confidentiality requirements. Federal law permits disclosure of information in State files which is directly connected to the administration of the program. The establishment of eligibility is a purpose directly connected to program administration. As such, Federal requirements do not preclude access to application information entered into the system. However, they do preclude giving a non-State employee access to eligibility information in State files about persons other than applicants on the application the non-State worker is initially processing.

Extend Opportunity to Apply to Families and Others

In addition to taking and initially processing applications from pregnant women and children, as required, States may consider extending the process to low-income families, dual-eligibles, and other applicants. Many children may be eligible for Medicaid under the section 1931 family group. It makes sense to provide these children and their parents the opportunity to apply for Medicaid-only coverage at the outstation site instead of requiring families to apply at the local welfare office. Several States have developed shortened family applications that are simple to complete and particularly appropriate for outstation sites and mail-in use. States have also found that training outstationed workers to be able to accept both State Children's Health Insurance Program (SCHIP) and Medicaid applications as well as those for the dual eligible elderly has been beneficial. Most states with separate SCHIP programs use joint SCHIP/Medicaid applications for children.

Combine Outstationing with Presumptive Eligibility

Another available option is to combine outstationing with presumptive eligibility for children. Sites where presumptive eligibility determinations can be made for children, such as FQHCs, hospitals, WIC offices, Head Start Centers, and Child Care Eligibility Centers, also can serve as outstation locations. By combining presumptive eligibility determinations and outstationing at the same locations, presumptively eligible children can receive immediate Medicaid coverage and can begin the process for determining his or her continuing eligibility for Medicaid without the need to go elsewhere to file a formal Medicaid applications. This will lessen the number of otherwise eligible children who lose Medicaid after a presumptive eligibility period because they failed to file a regular Medicaid application.

States can also combine outstationing with presumptive eligibility for pregnant women. Medicaid providers can presumptively enroll pregnant women in Medicaid to ensure that they can receive care pending a final determination of eligibility and, in addition, initially process the Medicaid application.

Use Outstation Locations in the Redetermination Process

States may consider using outstation locations to assist in the redetermination process. Retention is a major challenge for Medicaid programs, particularly when families and individuals do not reply to requests for information from the State in order to complete the redetermination process.

Outstation locations, such as FQHCs, could assist in the process when an individual is at the outstation site for a follow up visit. At least one State is piloting a “rolling redetermination” process under which the information needed to redetermine the family’s or individual’s eligibility is obtained when the family or individual is at the outstationed site. The redetermination/renewal process is thereby completed whenever the information is available, as long as it is done at least every 12 months. FQHCs, in particular, are well suited to this type of rolling redetermination process.

3. Staffing

A. Requirements

Hours of Staffing

Except for outstation locations infrequently used by pregnant women or children, States must have staff available at each outstation location during regular office operating hours of the State Medicaid agency to accept and initially process applications.

State failure to ensure adequate staffing at outstation sites has been reported as a major barrier to successful outstationing and enrollment strategies. If States do not have available staff, the State is obligated to make other arrangements to ensure that the minimum requirements of the regulations are met. For example, the outstationing requirement can be carried out by DSH hospital and FQHC staff, or by contractors, or volunteers. If States do not have sufficient staff for outstation sites, it is important that FQHCs and DSH hospitals understand that alternatives to the State staffing model can be used, and that states work with these facilities, as required, to implement alternative arrangements. Some States have contracted with their State Primary Care Association to manage and provide technical assistance to outstationed staff. Contact information for these organizations is currently available at www.bphc.hrsa.gov/osnp by double clicking on the Outreach and Enrollment button. Payment for outstationing activities is discussed below.

Staffing at Infrequently Used Locations

Initial application processing assistance must be provided at infrequently used locations but it is not necessary to have the location staffed with a full-time person during regular State Medicaid agency operating hours as noted above. Outstationing assistance must be provided at these locations during the regular operating hours (or when the location provides services during these hours) through staff on site or through telephone assistance, or a combination of both. On-site staff would include State staff, provider or contractor employees, or volunteers. The regulations provide that at these locations States must display a notice in a prominent place which advises

potential applicants of when outstation intake workers will be available and provides a telephone number that applicants may call for assistance when staff are not available. In addition, the regulations require compliance with Federal and State laws and regulations governing the provision of adequate notice to persons who are blind or deaf or who are unable to read or understand the English language.

The regulations do not define infrequently used location, and States have discretion to define this term utilizing reasonable criteria and guidelines. The definition must be related to infrequent use by pregnant women, infants, and children under 19; it is unlikely many DSH hospitals or FQHCs would properly be considered sites infrequently used by pregnant women and children in light of the patient mix at most DSH hospitals and FQHCs. The State's definition should be made publicly available.

Confidentiality and Conflict of Interest Requirements

The regulations provide that provider and contractor employees and volunteers are subject to the Federal confidentiality requirements that apply to Medicaid, and to State and Federal laws concerning conflicts of interest.

B. Options

Use Persons Other Than State Workers to Perform Certain Outstationing Functions

States may use State employees, provider or contractor employees, or volunteers who have been properly trained to staff outstation locations. As noted previously, only State employees so authorized may make eligibility determinations.

Non-agency staff may perform initial processing services provided they are properly trained. States also may work with local community-based organizations to identify volunteers. However, it is very unlikely that a State will be able to fully comply with its responsibility to ensure that outstationing is operating as intended in all required sites by relying solely or primarily on volunteers. Payment for non-agency staff is discussed below.

Extend Outstationing Hours to Coincide with Provider Operating Hours

While the regulations require the availability of staff at each outstation location during the regular working office hours of the State Medicaid office, frequently, these hours do not coincide with the hours of health centers, which regularly have evening and weekend hours. We strongly encourage States to extend outstationing hours to coincide with provider operating hours, which often are more convenient for families in which the parents work regular daytime shifts.

Rotate Staff Among Outstation Locations

The regulations allow States to station staff at outstation locations or to rotate staff among several locations as workload and staffing availability dictate. While rotation is an option, it does not override the obligation of the State to provide staffing at outstation locations during

regular office operating hours and to have either staff or telephone assistance at infrequently used locations. As a practical matter, rotation may be best suited as a means to provide staffing at infrequently used locations, or to cover evening or other nontraditional hours. States may also use State staff on a rotating basis to make eligibility determinations at several locations, or to provide guidance and assistance at several locations to provider staff or other persons performing initial processing activities.

4. Payment for Outstationing Activities

Requirements

Payment for Outstationing Functions

Staffing and resource limitations do not relieve States of the obligation to comply with and pay for the outstationing requirements of the law and regulations. Federal financial participation (FFP) is available in expenditures incurred by the State associated with outstation locations, regardless of whether the function is provided by a State or county employee or other person authorized to perform initial processing activities under the regulation. FFP is available for State expenditures for incurred outstationing costs at regular outstationing locations and at infrequently used and optional locations. The administrative functions of taking and processing applications are reimbursed at the 50 percent rate. Subject to the limitations noted below, this rate includes costs incurred by the State to implement and provide outstationing of intake workers who are

State employees, provider employees, volunteers, or contractor employees. The rate covers such necessary administrative costs as salaries, fringe benefits, travel, training, equipment, and space directly attributable to outstationing activities. To the extent that outstationing activities are directed at both Medicaid and SCHIP- eligible children, enhanced matching funds would be available for the SCHIP-related activities subject to the cap on SCHIP non-coverage expenditures.

Funding Under the \$500 Million Fund

Funding for some outstationing activities is also available under the \$500 million fund authorized under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) as part of cash assistance/Medicaid delinking. This fund can be used for a wide range of activities related to enrollment systems and outreach for individuals, including outstationing for individuals who could possibly be eligible under the Medicaid eligibility group for low-income families established by PRWORA in section 1931 of the Social Security Act. When a State performs such activities under—or related to—the 1931 provision, the State can consider the full cost of that activity as attributable to the enactment of section 1931. FFP is available under this fund at the 90 percent rate for outstationed staff, including State eligibility workers and provider employees; see Dear State Medicaid Director letter dated January 6, 2000

for further information. (This letter is available on HCFA's website at www.hcfa.gov). Funding under the \$500 million fund is not available for the minimum outstationing requirements mandated by Federal law (section 1902 (a)(55) and regulations at 42 CFR 435.904 (which were in effect prior to the enactment of PRWORA). However, the \$500 million fund would be available for new outstationing activity (including outstationing options beyond the minimum requirements) which is related to section 1931.

Use of Provider Donations

Provider-related donations made to a State by a hospital, clinic, or similar entity for the direct costs of State or local agency personnel who are stationed at the facility to determine eligibility or to provide outreach services may be used as the State share of such State costs, within a statutorily prescribed limit. Specifically, the provider-related donations for outstationed eligibility workers (i.e., State or local agency workers) are limited to 10 percent of a State's medical assistance administrative costs, excluding the costs of family planning activities. Direct costs of outstationed eligibility workers refers to the costs of training, salaries, and fringe benefits associated with each outstationed worker and a prorated cost of outreach activities applicable to the outstationed worker. The Medicaid statute permits this arrangement as an exception to the general prohibition on provider-related donations. The exception does not apply to donations made by a hospital, clinic, or similar entity for the direct costs of non-State personnel.

Financial Obligation of the State

Although FQHCs and DSH hospitals contribute toward the cost of outstationing in several states, they are not obligated to do so. The State is not relieved of its financial obligation to implement outstationing at a provider location if the provider is unwilling or unable to contribute toward the cost of the outstationing arrangements. The State must arrange for outstationing at that location consistent with the requirements and options of the law and regulations.

Review of State Outstationing Arrangements

As part of our reviews of State enrollment practices in delinking Medicaid/TANF, HCFA received information regarding State outstationing arrangements. We were made aware of shortcomings in some States and successful outstationing efforts in other States. The DHHS Office of the Inspector General is following up on these reviews to examine State compliance with Federal requirements and to help identify model strategies.

We encourage States to review their outstationing arrangements in light of this guidance and to come into compliance with the law and regulations promptly if they are not already in full compliance. States that seek to meet their outstationing obligations under an alternate plan must submit a SPA; in the absence of a SPA, the State will be held to the minimum requirements set forth in the law and regulations. Our goal in providing this guidance is to clarify Federal rules

and opinions, and to offer technical assistance and encouragement so that innovative outstationing arrangements will continue to flourish. Outstationing has proven to be a very successful outreach and enrollment strategy for States seeking ways to reach families outside of the welfare office.

If you have any questions or would like technical assistance with respect to these outstationing requirements and options, please contact your regional office.

Sincerely,

/s/
Timothy M. Westmoreland
Director

cc:
HCFA Regional Administrators

HCFA Associate Regional Administrators for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors' Association



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Center for Medicaid and State Operations

7500 Security Boulevard

Baltimore, MD 21244-1850

SMDL #01-025

July 19, 2001

Dear State Medicaid Director:

This is one in a series of letters regarding American Indian and Alaska Native (AI/AN) health policy issues and the Medicaid program. This letter follows up on the outstationing letter (enclosed) you received from the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, regarding the requirement that states provide pregnant women and children opportunities to apply for Medicaid at locations other than welfare offices, such as Federally Qualified Health Centers (FQHCs) and disproportionate share hospitals (DSH). This letter describes how your states may work with Federally-recognized Tribes and Urban Indian health care facilities to ensure these requirements are being met at Tribal facilities operating under an agreement with the Indian Health Service in accordance with the Indian Self-Determination and Education Assistance Act (Public Law 93-638), and FQHCs and DSH hospitals operated by Tribes or Urban Indian organizations.

The outstationing letter discussed the requirements for states to establish outstation locations at DSH hospitals and FQHCs participating in the state's Medicaid program, unless CMS approves an alternate plan that includes other sites and at least some DSH hospitals and FQHCs. FQHCs meet specific definitions described in section 1905 (1)(2)(B) of the Social Security Act. The letter further specifies that the FQHC definition also "includes an outpatient program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary care services." Also, please be aware that Section 708 of the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA) adds new entities to the list of those qualified to make Medicaid presumptive eligibility determinations for children. These new entities include agencies that determine eligibility for Medicaid for the State's Children's Health Insurance Program or certain elementary and secondary schools including those operated or supported by the Bureau of Indian Affairs, a state or Tribal child support enforcement agency or an organization that is providing emergency food and shelter under the Stewart B. McKinney Homeless Assistance Act.

Many AI/ANs who are eligible for Medicaid have chosen not to apply for Medicaid because of distance, language, and cultural barriers. States may use properly trained Tribal members or other trained individuals who are not state employees to perform outstationing services in a Tribal or Urban Indian facility. A trained Tribal member or

other trained individual performing the permissible outstationing services onsite at the Urban Indian health care facility, Tribal FQHC or other sites added by BIPA could help to overcome these barriers and increase Medicaid enrollment. Outstationing a Tribal member or other trained individual at a Tribal facility may also help overcome Tribal reluctance to having a state employee outstationed on Tribal lands.

Also, as a result of the December 19, 1996 Memorandum of Agreement (MOA) between CMS and the Indian Health Service, states may claim 100 percent federal medical assistance percentage (FMAP) for expenditures made for Medicaid services provided to Medicaid eligible AI/ANs by any Tribal facility operating under an agreement pursuant to the Indian Self-Determination and Education Assistance Act (Public Law 93-638). However, the MOA does not allow for 100 percent FMAP for states at Urban Indian health care facilities because they do not operate under the authority of Public Law 93-638. Expenditures for the administrative functions of taking and processing Medicaid applications in Urban Indian facilities are reimbursed at the 50 percent Federal financial participation rate applicable to administrative expenditures.

We encourage you to work with the Tribal FQHCs, Urban Indian health care facilities and other appropriate facilities in your states to ensure the outstationing requirements are being met in a manner that is mutually acceptable.

If you have any questions or would like technical assistance regarding this letter, please contact the Native American Contact (NAC) in the appropriate CMS Regional Office. A list of the NACs is enclosed. You will receive a copy of a letter to the Tribal Leaders in your state transmitting this letter.

We look forward to working with you in the future on this and other efforts.

Sincerely,

/s/

Penny R. Thompson
Acting Director

Enclosures

Cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Health Services Association

Joy Wilson
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National Conference of State Legislatures

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James Mason
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